EXAMPLE -- RETIREE STATEMENT OF CURRENT COVERAGE
To be completed by Agency Payroll Personnel

Name JOHN DOE **SABHRS ID** 000000

Address 123 RETIREE LANE **SSN#** 123-45-6789

RETIREE CITY, AZ **Current Coverage As Of (MM/YY)** JAN 2008

Termination Date: 1/26/2008

Instructions: Agency payroll personnel will write down the employee's current coverage, as shown in SABHRS, as of the first day of the pay period in which the employee retires. **This form is only used for retiring employees who are eligible for continuation of benefits and wish to pre-pay premiums**. The retiring employee will use this form to make coverage decisions on the Retiree Election Form.

You are currently enrolled in the **TRADITIONAL** Medical Plan	Change my medical plan to: ☐ Traditional ☐ Managed Care-PEAK ☐ Managed Care – Blue Cross/Blue Shield ☐ Managed Care – New West Health Plan **You can only elect a new plan with a deductible that is higher than your current deductible.**

**********MEMBERS ELIGIBLE FOR CONTINUATION OF COVERAGE**********

Type* of Coverage	Name	Relationship**	Birthdate	SSN
M, D, V	JOHN DOE	SELF	01/14/40	123-45-6789
M, D, V	JANE DOE	SP	04/18/53	222-33-1234
M. D, V	JOHN DOE JR	S	03/2/80	111-44-7777

*Type: M = Medical; D = Dental; V=Vision
**Relationship: Sp = Spouse; DP = Domestic Partner; D = Daughter; S = Son; X = Disabled

☐ Check here if you are eligible for Medicare ☐ Check here is your spouse is eligible for Medicare
If you or your spouse is eligible for Medicare, please provide us a copy of your Medicare card, so we can provide you the lower Medicare rate.

RETIREE ELECTION FORM
To be completed by Retiring Employee

If you are retiring from state employment, and you are eligible to receive a benefit according to the provisions of your particular retirement system, you may continue your insurance coverage as a Retiree.

Please read through the "**Retiree Letter**" for information on your options **before** making your elections**.** You may only elect to continue coverage just before or within 60 days after your coverage as an active employee ends. If you pre-pay premiums for your elections, you will not get a refund if your coverage changes before your pre-payment runs out. Elections made on this form cannot be changed until the next Annual Change Period, effective the first day of the next year.

INSTRUCTIONS: 1) Have your payroll clerk complete your "Statement of Current Coverage" (above). 2) On the Statement, Circle the names of dependents you will continue to cover after retirement, and the type of coverage to be continued (medical and/or dental and/or vision). 3) Check the box next to the medical plan you wish to elect (above), if changing your current election. 4) Check your method of premium payment (below). 5) Sign and date this form and return to the Health Care and Benefits Division, address below.

METHOD OF PAYMENT (please choose one):
_____Monthly deduction from PERA benefit
_____Monthly Self-Payment to Health Care and Benefits Division by check which would include VEBA if eligible
_____ Electronic Premium Deduction from Checking or Savings (Attach Authorization Form).
(If you are pre-paying some months of coverage, your preferred method of payment will begin when the pre-payment period ends.)

I hereby elect to continue the coverage selected above with the State of Montana Employee Group Benefits Plan. This coverage will remain in effect unless I change my coverage election, my dependents lose eligibility or I fail to pay the required premiums by the due date. I understand that premiums may be adjusted for any future increases or decreases in the cost of the coverage(s) I have selected.

Signature_____ **Phone:** _____

Date _____

STATE PERSONNEL USE ONLY	PERA USE ONLY
Retiree Coverage effective:_____	**PERA deduction to begin:** _____
Total Payment Due:_____	**Retirement Number:** _____
Authorized by: _____	**Date Processed:** _____

Distribution: Return the completed **white copy** to the Health Care and Benefits Division PO Box 200127, Helena, MT 59620-0127. Keep the **colored copy** for your records. If you have any questions, call us at 1-800-287-8266 or 444-7462 if in Helena, or e-mail us at BenefitsEligibility@mt.gov .

Revised 12/07